DENTAL BENEFITS MANAGER PROGRAM
PROPOSED EFFECTIVE DATE: 02/01/2006

PROGRAM OVERVIEW
EFF:02/2006

The Dental Benefits Manager Program is a statewide dental benefits managed care delivery system established under a Title XIX waiver. The program's goal is to improve access to oral health services for Rhode Island children who receive Medical Assistance. Emphasis is placed on preventative and primary care dental services and education.

Children born on or after May 1, 2000 who are receiving dental benefits through Medical Assistance are enrolled in a Dental Benefits Manager (DBM) organization. The Department of Human Services (DHS) contracts with DBMs to provide oral health services to members at a pre-paid capitated rate. The DBM is responsible for establishing and maintaining a network of dentists, all member services, and processing dental claims.

Legal Authority
EFF:02/2006

Title XIX of the Social Security Act provides the legal authority for the Medical Assistance Program. The Dental Benefits Manager Program operates under a waiver under the authority of Section 1915(b) of the Social Security Act.

COVERAGE GROUPS
EFF:02/2006

Participation in the Dental Benefits Manager Program is mandatory for all children in the following populations who were born on or after May 1, 2000 and who are receiving Medical Assistance:

1. Section 1931 Children and Related Populations (Including Poverty Level Groups and Family Independence Program Cash Recipients)
2. Blind and/or Disabled Children
3. Foster Care Children who are receiving foster care or adoption subsidy assistance (Title IV-E), are in foster care, or are otherwise in an out-of-home placement.

EXCLUDED COVERAGE GROUPS
EFF:02/2006

The following groups are excluded from participation in the Dental Benefits Manager Program:

1. Children born on or before April 30, 2000;

2. Children who have access to third party dental benefits;

3. Children who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

4. Children who reside outside of the State of Rhode Island.

Those children who are not eligible to participate in the DBM Program receive dental benefit coverage under the Fee For Service System.

RETROACTIVE ELIGIBILITY
EFF:02/2006

If a member is eligible for retroactive eligibility, the DBM does not provide coverage to Medical Assistance beneficiaries during the period of retroactive eligibility.

PRIOR AUTHORIZATION
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Dental Services:

Prior authorization requirements for dental services under this program are identical to those required under the Medical Assistance Fee For Service System.

Dental Specialists:

Formal Prior Authorizations will not be required for a beneficiary who is enrolled in a DBM program to be treated by a dental specialist. This includes, but is not limited to, oral surgeons, endodontists, periodontists, pediatric dentists, orthodontists, and prosthodontists.

ENROLLMENT PROCESS
EFF:02/2006

Applicants/beneficiaries may have a choice of DBMs in which to enroll. The enrollment process insures that applicants/beneficiaries will be provided with sufficient information (if a choice of DBMs is available) in order to make an informed choice when deciding upon which DBM to enroll in. This information will include DBM marketing brochures and other materials which the applicant/beneficiary will receive at the point of application.—

Applicants/beneficiaries have fourteen (14) days to enroll in a DBM. If a selection is not made within fourteen (14) days, children will be automatically enrolled in a plan. Applicants/beneficiaries will be notified in writing of the DBM to which they have been assigned.

VOLUNTARY SELECTION OF A DBM
EFF:02/2006

Applicants/beneficiaries have fourteen (14) days to select and enroll in a DBM. All eligible children in the family must select the same DBM.

AUTOMATIC ASSIGNMENT INTO A DBM
EFF:02/2006

Those DBM-eligible member families who neglect to indicate their choice of DBM within the fourteen (14) day time period are automatically assigned into a DBM in sequential order (i.e., DBM A, then DMB B, etc.). RIte Care members are default automatically assigned to a DBM affiliated with their Health Plan, if any. Fee-For-Service Medical Assistance beneficiaries who do not make a DBM choice, RIte Share enrollees, and RIte Care families in a Health Plan that does not have an affiliated DBM contracting with the State, are assigned in sequential order to one of the participating DBMs.

AUTOMATIC RE-ENROLLMENT, FOLLOWING RESUMPTION OF ELIGIBILITY
EFF:02/2006

Members who are disenrolled from a DBM due to loss of eligibility are automatically re-enrolled into the same DBM should they regain eligibility within ninety (90) days. If more than ninety (90) days have elapsed since the member regained enrollment, the members are

treated as new members and are allowed to select the same or different DMB via the Medical Assistance application.

DENTAL BENEFITS MANAGER LOCK-IN
EFF:02/2006

Following ninety (90) days after their initial enrollment into a DBM, enrollees are restricted to that DBM until the next open enrollment period, unless disenrolled under one (1) of the conditions described below:

- Loss of Medical Assistance eligibility including for non-payment of applicable premium shares for RIte Care or RIte Share;
- Selection of another DBM during open enrollment;
- Death;
- Relocation out-of-state;
- Adjudicative actions;
- Change of eligibility status;
- Eligibility determination error;
- As the result of a formal grievance filed by the member against the DBM or by the DBM against the member;
- Just cause (as determined by the State.

OPEN ENROLLMENT
EFF:02/2006

During open enrollment members have an opportunity to newly select or to change DBMs.

VOLUNTARY DISENROLLMENT
EFF:02/2006

DBM members seeking disenrollment during the lock-in period must first file a formal appeal pursuant to grievance and appeal procedures with the DBM (with the exception that members are permitted to disenroll

without cause during the ninety (90) days following the effective date of the individual's initial enrollment). Disenrollment can only be ordered by CCFH after administrative review of the facts of the case. In order for disenrollment to occur, CCFH must first find in favor of the member, and then determine that the appropriate resolution to the member's complaint is the member's disenrollment.

MEMBER DISENROLLMENT
EFF:02/2006

Unless the member's continued enrollment in the DBM seriously impairs the DBM's ability to furnish services to either the particular member or other members, a DBM may not request disenrollment of a member because of:

- An adverse change in the member's health status;
- The member's utilization of medical services; or,
- Uncooperative or disruptive behavior resulting from the member's Special needs.

All disenrollments are subject to approval by the State.